PRIMARY APPLICANT NAME ______________________ DATE ______________

DEPENDENT NAME (If submitted separately) ______________________________

F Additional Information – Separate Sheet

If you answered "YES" to any of the questions in Section E, you must provide additional information below.

Question Number: ____ **Name of Individual:** ____________

Condition/Diagnosis: ______________________________

Treatment Received: ______________________________

____

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ______________

Additional tests or treatment recommended? ______________

Medication Prescribed (if any): ______________

______________ Currently taking medication? ☐ Yes ☐ No

Physician Name ______________________________

Phone # (________)______________ City & State ______________

Question Number: ____ **Name of Individual:** ____________

Condition/Diagnosis: ______________________________

Treatment Received: ______________________________

____

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ______________

Additional tests or treatment recommended? ______________

Medication Prescribed (if any): ______________

______________ Currently taking medication? ☐ Yes ☐ No

Physician Name ______________________________

Phone # (________)______________ City & State ______________

Question Number: ____ **Name of Individual:** ____________

Condition/Diagnosis: ______________________________

Treatment Received: ______________________________

____

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ______________

Additional tests or treatment recommended? ______________

Medication Prescribed (if any): ______________

______________ Currently taking medication? ☐ Yes ☐ No

Physician Name ______________________________

Phone # (________)______________ City & State ______________

Signature: ______________________________ Date: ______________